***COMMONWEALTH OF MASSACHUSETTS*** ***DEPARTMENT OF PUBLIC HEALTH***

**Clinical Laboratory Program**

99 Chauncy Street, 2nd Floor, Boston, MA 02111

(617)753-8439/8438 (617) 753-8240 - Fax

# BLOOD BANK MONTHLY ACTIVITY REPORT
## Directions for completion of form

Complete and return no later than **10** calendar days following the end of a calendar month.

Clinical Laboratory Program
**99 Chauncy Street, 2nd Floor**
**Boston, MA 02111**
**Phone 617-753-8438 Fax 617-753-8240**

**Page 1**

### Blood Bank Demographics

Complete all information:

Facility number (page 1 and 2), Name, Address, Bed Size

Names of Blood Bank Medical Director and Supervisor

Blood Bank phone number (include area code)

### Adverse Effects of Transfusions

DISEASE TRANSMISSION SOURCES

Enter the source of the units (BB donor program, American Red Cross, National Blood Exchange, etc.) – include state if from a non-Massachusetts source

REACTIONS – IMMEDIATE

Immediate Hemolytic Reactions due to ABO incompatibility

enter on this report and also report immediately to the DPH – Clinical Laboratory Program [617-753-8065 or 8060]

Immediate Hemolytic Reaction (non-ABO)

Enter total number and specify the antibody which caused the reaction

REACTIONS – OTHER

Enter total number of each reaction type

**use the American Association of Blood Bank definitions found in the most recent edition of the Technical Manual**

### Source of Products

Enter the overall ***estimated*** percent for each source listed

**NOTE:**

A serious incident report **MUST** be filed with the DPH whenever a patient receives an incorrect unit of blood even if it is type compatible (e.g., unit given to wrong patient, wrong patient receives blood, patient mis-typed). Information relating to the reporting of a serious incident can be found in Circular Letter: DHCQ-12-98-385 – Hospital Reporting of Serious Incidents, which was sent to all hospitals in December 1998.

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## STATISTICS

Statistics are to be reported by the Blood Bank providing crossmatch services and should include all units for all facilities supported by the Blood Bank (e.g., hospitals, End Stage Renal Dialysis facilities, Transitional Care Units, etc.). Facilities which provided Transfusion Services ONLY should not report their statistics on this form.

Blood Bank – a facility equipped and staffed to procure, draw, process, store and/or dispense blood and/or blood components.

Transfusion service – a service designed, equipped and staffed to dispense and/or administer blood and/or blood components.

Complete the data by entering one digit per box, ending in the farthest right hand box.

| | | | | | |
|---|---|---|---|---|---|
| 0 | 0 | , | 0 | 6 | 4 |

**TRANSFUSED UNITS:** blood product units which are not wasted and/or transferred. Report individually as Transfused; Transfused Washed; or Transfused Autologous.

**WASTED UNITS**: blood product units which are not transfused and/or transferred. Report as Wasted [includes washed, if applicable] and Wasted Autologous.

**TRANSFERRED UNITS**: report number of units received into inventory and then transferred to another Blood Bank.

**TOTAL CROSSMATCHES**: report number of crossmatches [full, immediate spin, computer] performed for Whole Blood and Red Blood Cells.

**TOTAL IRRADIATED BLOOD PRODUCTS**: report the total number of units of blood/blood components that were irradiated before infusion. Irradiated units are not to be counted separately in the above reported statistics.

# BLOOD BANK MONTHLY ACTIVITY REPORT

Facility # _____ Month ____/_____

**Name of Facility** _____

**Street/City/Zip** _____

**BB Medical Director** _____

**BB Supervisor** _____

**BB Phone Number** _____ **Bed Size** _____

**ADVERSE EFFECTS OF TRANSFUSIONS**

| **Disease Transmission Sources** | **Number** | **Source of Units** |
|---|---|---|
| Hepatitis B | _____ | _____ |
| Hepatitis C | _____ | _____ |
| Hepatitis Other | _____ | _____ |
| HIV / AIDS | _____ | _____ |
| Other _____ (SPECIFY) | _____ | _____ |

**Reactions**

| | |
|---|---|
| Immediate Hemolytic (ABO) | _____ |
| Immediate Hemolytic (Other) | _____ |
| Delayed | _____ |
| Febrile | _____ |
| Non-hemolytic | _____ |
| TRALI | _____ |
| GVHD | _____ |
| Bacterial Assoc Contamination | _____ |
| Plt - Refractory | _____ |
| Other _____ (SPECIFY) | _____ |

**MUST be reported to DPH IMMEDIATELY**

Specify _____

**Source of Products** (Estimate Percent)

| | |
|---|---|
| On-Site Donor Program | _____ % |
| American Red Cross | _____ % |
| Other Local Sources | _____ % |
| Out-of-State Sources | _____ % |

**NOTE:**

A serious incident report **MUST** be filed with the DPH whenever a patient receives an incorrect unit of blood even if it is type compatible [e.g., unit given to wrong patient, wrong patient receives blood, patient mis-typed].

# BLOOD BANK MONTHLY ACTIVITY REPORT

Facility # _____ Month ____/_____

| | | Transfused | Transfused Washed | Transfused Autologous |
|---|---|---|---|---|
| **WHOLE BLOOD** | | | | |
| **RBC** | **-Packed** | | | |
| | **-Froz/Gly** | | | |
| | **-Leukoreduced** | | | |
| **PLTS** | **-Conc** | | | |
| | **Leukoreduced** | | | |
| **PLTS** | **-Pheresis** | | | |
| | **Leukoreduced** | | | |
| **PLASMA** | **-Fresh Frozen** | | | |
| | **-Solvent/Detergent** | | | |
| **CRYOPRECIPITATE** | | | | |

| | | Wasted | Wasted Autologous | Transferred |
|---|---|---|---|---|
| **WHOLE BLOOD** | | | | |
| **RBC** | **-Packed** | | | |
| | **-Froz/Gly** | | | |
| | **-Leukoreduced** | | | |
| **PLTS** | **-Conc** | | | |
| | **Leukoreduced** | | | |
| **PLTS** | **-Pheresis** | | | |
| | **Leukoreduced** | | | |
| **PLASMA** | **-Fresh Frozen** | | | |
| | **-Solvent/Detergent** | | | |
| **CRYOPRECIPITATE** | | | | |

**Total Crossmatches** | **Total Irradiated Blood Products**